STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. BUILDING _____ B. WING _____	C 09/17/2010

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NORTHPOINT/LEXINGTON HEALTHCARE CENTER	1600 TRENT BOULEVARD LEXINGTON, KY 40515

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F 000	INITIAL COMMENTS A Standard Recertification and an Abbreviated Survey investigating ARO#KY00014427, ARO#KY00014428, ARO#KY00014429, ARO#KY00015014, ARO#KY00015330, ARO#KY00015331, ARO#KY00015268, ARO#KY00015269, ARO#KY00015270, and ARO#KY00015271 was initiated on 09/14/10 and concluded on 09/17/10. A Life Safety Code Survey was conducted on 09/16/10. Deficiencies were cited with the highest scope and severity of a "F". ARO#KY00014429, ARO#KY00015014, and ARO#KY00015269 were substantiated with deficiencies cited. All other ARO's were unsubstantiated with no deficiencies cited.	F 000	It is the practice of this facility to ensure location of transfer is included in any written notice of discharge. Resident #22 no longer resides at the facility. A discharge location was not included on Resident #22's discharge notice as the family was unable to adequately provide care for the resident and a discharge to the family resident was not felt to be appropriate. The facility Administrator and Social Services were assisting the family in finding appropriate placement.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered	F 203	On 9/17/10 the Administrator reviewed all issued discharge letters on file to check that the location requirement was met. The audit revealed no incomplete location requirements. On 9/17/10 the Administrator reviewed the regulatory requirements for admission, discharge and transfer requirements and re-educated the Social Services Staff on the requirements.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Thornton	Administrator	10/31/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to include the location to which the resident was transferred or discharged, in the written notice of intent to discharge, for one of twenty-four (24) sampled residents (Resident #22).	F 203	**Any written discharge issued during the next 12 months will be audited by the Administrator/Social Service Director to validate notice requirements are met in the content and to monitor ongoing compliance with notice and regulatory requirements.** **Results of the audits will be reviewed by the facility QA Committee with revision of the plan as deemed necessary by the Committee.** **The Administrator and Social Service Director will be responsible for overall compliance.**	10/29/10

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F 203	Continued From page 2 The findings include: Review of Resident #22's closed record revealed an admission date of 12/23/09 and diagnoses which included Alzheimer's, Dementia with behaviors, Anxiety and Psychosis. Review of the Admission Minimum Data Set (MDS) dated 01/05/10 revealed the facility assessed Resident #22 as having both short and long term memory deficits and as being moderately impaired with cognitive skills for daily decision-making. Review of the Resident Assessment Protocol Summary (RAPS) dated 01/05/10 revealed the resident triggered for mood and behaviors related to persistent anger, altered perception, wandering, and resisting care. Review of the intent to discharge letter sent to the resident and his/her spouse by the facility Administrator, dated 01/13/10, revealed the facility would discharge the resident on 02/13/10 "due to the safety and well-being of yourself and other residents of this facility." The letter of intent to discharge did not reveal a location to which the resident would be transferred or discharged. Interview with the Administrator on 09/16/10 at 11:15 AM revealed she considered the notice a letter of "intent" and would not have discharged the resident on 02/13/10 if no location to which the resident would be transferred had been found by that date. She stated she had been working with the family to find a location but had not been successful because no facility wanted to accept the resident due to his/her numerous aggressive	F 203		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 203	Continued From page 3 behaviors. The Administrator stated the family understood this was only a letter of intent, meant to protect the resident and other residents of the facility, with the offer to assist the family in finding another facility of the family's choosing. Interview on 09/17/10 at 10:00 AM with Resident #22's granddaughter revealed there was no location provided in the notice to which the resident would be discharged and the family was upset and stressed because they could not care for the resident at home and knew of no place to take the resident. The granddaughter further stated that when they attempted to find a suitable facility for Resident # 22, no facility would accept the resident when they read the Nurse's Notes from the current facility. The granddaughter stated the family believed Resident #22 would be discharged from the facility on 02/13/10 regardless of finding a suitable facility for the resident. She stated the resident's surviving spouse was traumatized by this prospect and had to seek medical help due to this situation.	F 203		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	**It is the practice of this facility to develop, review and revise each resident's comprehensive care plan in order to meet the medical and nursing needs of all residents.** **The comprehensive care plans for Residents #13 and 14 were updated on 9/17/10 by the MDS Coordinator to reflect oxygen administration for the residents.**	

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F 279	Continued From page 4 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a Comprehensive Care Plan was developed to meet the medical and nursing needs for two (2) of twenty-four (24) sampled residents (Resident #13 and Resident #14). The facility failed to ensure the administration of oxygen was addressed in the Comprehensive Care Plan. The findings include: 1 . Review of the clinical record revealed Resident #13 was admitted with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Anxiety and Hypertension (HTN). Review of the Physician's order dated 03/02/10, revealed an order for Oxygen (O2) at two (2) liters per minute per nasal cannula to maintain O2 saturation above ninety percent (90%). Review of the Comprehensive Care Plan dated 06/04/10, revealed no documented evidence the facility addressed the resident's use of O2 and/or the risk/safety factors related to O2 therapy. 2. Review of the clinical record revealed Resident	F 279	**Facility Administrative Nurses reviewed current residents' comprehensive care plans on 9/25/10 for completeness of orders/interventions to meet the medical, nursing and psychosocial needs of each resident. These reviews also included that oxygen administration was on applicable residents care plans.** **On 9/17/10 the DON re-educated facility administrative nurses on initiating and revising comprehensive plans of care.** **The facility CQI team will meet daily 5 days a week to review and discuss updates to resident's care plan for development and revision of medical, nursing and psychosocial needs identified in the comprehensive assessment and with any change of condition. Unit managers will monthly review all resident comprehensive care plans to ensure ongoing compliance.**	

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F 279	Continued From page 5 #14 was admitted on 02/09/10 with diagnoses which included Alzheimer's Disease, Diabetes, and Basal Cell Carcinoma. Review of Resident #14's clinical record revealed a Physician's order dated 09/01/10, for Oxygen at two (2) liters per minute by nasal cannula, and to maintain the oxygen saturation level above ninety (90) percent. In addition, the Physician's order indicated the resident was to have the oxygen saturation level checked every shift. Observations throughout the survey revealed the resident was receiving the oxygen as ordered. Review of the Comprehensive Plan of Care updated on 06/02/10, revealed no interventions related to the resident's administration of oxygen, the checking of the resident's saturation levels, the monitoring of the resident's respiratory status, or maintaining the equipment. Interview with the Unit Manager (UM) where Resident #14 resided on 09/16/10 at 3:00 PM, revealed he reviewed new orders daily. He stated it was his responsibility to ensure the care plan had been updated to reflect new orders, or any change in status. Continued interview revealed the UM revealed he was unsure as to why Resident #14's plan of care was not updated as indicated by the new order for oxygen administration. Interview on 09/17/10 at 11:55 PM with the Director of Nursing, revealed the Comprehensive Care Plan should have been developed and/or revised by the nurse when the order was taken and the Unit Manager should have ensured the care plan was updated.	F 279	**A 10% facility wide audit will be completed monthly by the QA Nurse of comprehensive care plans for inclusion of medical, nursing and psychosocial needs.** **Results of the audits will be reviewed in the monthly QA Committee meeting with revision of the plan as deemed necessary by the Committee.** **The Administrator, Maintenance Director, DON/Designee will be responsible for overall compliance.**	10/29/10
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 6 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to review and revise the Comprehensive Plan of Care for two (2) of twenty-four (24) sampled residents (Residents #2 and #13). The plan of care failed to reflect the discontinuation of a Geri chair for Resident #2. Resident #13's plan of care was not revised to include required assist of one (1) person for meals and a treatment related to a wound. The findings include:	F 280	**It is the practice of this facility to review and revise the comprehensive care plan of all residents. The care plan for resident #2 was revised by the Unit Manager on 9/17/10 to reflect the discontinuation of the geri chair with implementation of wheelchair utilization per therapy recommendation.** **The care plan for resident #13 was revised by the Unit Manager on 9/17/10 to reflect assessed assistance needed for meal consumption and current wound treatment.** **Facility Administrative Nurses reviewed current residents' comprehensive care plans on 9/17/10 for completeness of orders/interventions and revisions to meet the assessed medical, nursing and psychosocial needs of each resident.** **On 9/17/10 the DON re-educated facility administrative nurses on initiating and revising comprehensive plans of care.**	

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F 280	Continued From page 7 1. Review of the clinical record revealed Resident #13 was admitted 04/23/09 with diagnoses which included Chronic Obstructive Pulmonary Disease, Macular Degeneration, and Debility. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/01/10, revealed the facility assessed the resident as requiring one (1) person assist with meals related to the resident's being highly impaired. Review of the care plan dated 06/04/10, revealed no evidence the facility had developed a plan of care related to Resident #13's need to be assisted by one staff while eating Record review revealed on 07/27/10, Resident #13 spilled hot coffee and received a second degree burn measuring 1.5 centimeter by 1.5 centimeter to the abdomen, and sustained redness to the right arm and thigh related to the spilled coffee. Review of the Nurses Notes and care plan update revealed on 08/31/10, the arm and leg wounds were resolved and treatment was stopped. The abdominal wound treatment was changed to a dry dressing until resolved. Review of the Physician's orders revealed an order dated 09/10/10 for a treatment to the abdominal wound and on 09/14/10 a different treatment order was received. Review of the Care Plan revealed the facility resolved the care plan related to the wound; however, the facility failed to revise the care plan on 09/10/10 when the wound reopened and new treatment orders were obtained. Interview on 09/17/10 at 11:55 AM with the Director of Nursing, revealed the care plan should	F 280	**The facility CQI team will meet daily 5 days a week to review and discuss updates to residents care plan for development and revision of medical, nursing and psychosocial needs identified in the comprehensive assessment and with any change of condition. Unit managers will monthly review resident comprehensive care plans to ensure ongoing compliance.** **A 10% facility wide audit will be completed monthly by the QA Nurse of comprehensive care plans for inclusion of assessed medical, nursing and psychosocial needs.** **Results of the audits will be reviewed monthly by the QA Committee with evaluation of need for further intervention or change of the monitoring plan as deemed necessary by the committee.** **The Administrator, DON, QA Nurse and Unit Managers will be responsible for overall compliance.**	10/29/10

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F 280	Continued From page 8 have been updated on 09/10/10 when the wound status had worsened. Further interview revealed the Nurse who received the order should have updated the care plan. Record review and interview with the Administrator on 09/16/10 at 9:15 AM, revealed in response to this incident the facility immediately in-serviced all staff that beverages were not to be warmed for any resident; all microwaves were placed behind locked doors; and, licensed staff were educated related to standards and proper food temperatures. The facility also assessed all residents to ensure the facility was providing proper assistance with meals. Further, the facility conducted a Quality Assurance meeting on 07/28/10 to implement action plans related to the incident and informed the Medical Director of the facility's action. The facility then put audit tools into place to monitor point of service temperatures, appropriate supervision during meals, and staff knowledge. 2. Review of the clinical record for Resident #2 revealed an admission date of 03/09/10. The resident's diagnoses included Traumatic Hip Fracture, Fractured Neck of Femur, Alzheimer's Disease, General Osteoarthrosis, and Muscle Weakness. Review of the Resident #2's Comprehensive Care Plan revealed the resident was care planned on 07/22/10 for the use of a Geri-chair related to decreased muscle control secondary to Alzheimer disease. Observation on 09/14/10 at 11:55 AM and 12:20 PM, revealed Resident #2 sitting in a wheelchair eating lunch with assistance from an aide.	F 280		

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F 280	Continued From page 9 Observation on 09/14/10 at 4:30 PM, revealed Resident #2 sitting in a wheelchair in the dining area while watching television. Observation on 09/14/10 at 6:45 PM, revealed Resident #2 sitting in a wheel chair in the hallway next to another resident. Observation on 09/15/10 at 10:00 AM, revealed Resident #2 appeared to be sleeping soundly in the his/her room, no Geri chair noted. A wheelchair was observed to be present in Resident #2's room. Observation on 09/15/10 at 12:00 PM, revealed Resident #2 was sitting in a wheel chair eating lunch. Interview with Unit Coordinator #1 on 09/15/10 at 4:15 PM, revealed Resident #2 had been in a Geri chair while therapy had been working with the resident due to pressure and positioning. He further indicated the resident did not currently have a Geri chair, and was using the wheelchair. He stated Therapy felt it was appropriate to discontinue the Geri chair and return the resident to the wheelchair. Per interview, the Geri chair should have been removed from the resident's care plan.	F 280	It is the practice of this facility to provide and arrange service by qualified person in accordance with each resident's written care plan. The seat belt for Resident #11 has been released during meals and re-fastened after meals. Resident #11 has been transferred and repositioned with 2 person assist. Nurse aide #3 was released from employment on 5/23/10. Facility Administrative Nurses reviewed that the care provided to current residents was in accordance with each resident's comprehensive care plans on 9/17/10.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation , interview, and record review it was determined the facility failed to	F 282	Incident reports for 60 days prior to 10/25/10 were reviewed by administrative nurses for implementation of care plan interventions.	

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F 282	Continued From page 10 follow the Comprehensive Care Plan for one (1) of twenty-four (24) sampled residents (Resident #11). Resident #11's seat belt was not released during meals. In addition, Resident #11 was care planned for two (2) person assistance with care needs. On 05/23/10 only one Certified Nursing Assistant (CNA) provided assistance with care needs, and Resident #11 obtained a skin tear during care. The findings include: 1. Review of Resident #11's medical record revealed the resident was admitted to the facility with diagnoses which included Alzheimer's Dementia, Aphasia, status post left humeral fracture, and Parkinson's Disease. Review of the facility restraint evaluation dated 08/31/09, revealed the resident required the use of a seat belt restraint due to the lack of safety awareness. Review of the restraint assessment dated 08/24/10, revealed the seat belt was to be released during meals. Review of the Resident's Comprehensive Care Plan revealed the resident was care planned to have the seat belt released during meal time and refastened after eating. Observation on 09/14/10 at 11:15 AM, revealed Resident #11 was sitting in a wheel chair in the dining room being assisted with eating lunch by a family member with the seat belt buckled. Observation on 09/14/10 at 6:00 PM of Resident #11 during the evening meal, revealed the seat belt was still intact while the resident was eating dinner.	F 282	**Re-education was provided by the Staff Development Coordinator to staff on 5/24/10 and 10/1/10 regarding following resident's established plan of care.** **Provision of care audits will be completed by the QA Nurse/Administrative Nurses to monitor that provision of resident care is congruent with the care plan interventions which are based on the residents assessed needs. The audits will be completed 3 times weekly for 2 weeks, then weekly for 2 weeks and then monthly.** **Audit results will be reviewed monthly by the QA Committee with revision of the plan/monitoring as deemed by the QA Committee.** **The Administrator, DON, and QA Nurse will be responsible for overall compliance.**	10/29/10

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F 282	Continued From page 11 Observation on 09/16/10 at 12:00 PM of Resident #11 during the lunch meal, revealed the seat belt was still in tact while the resident was eating. Interview with Unit Coordinator #1 on 09/15/10 at 4:15 PM, revealed the seat belt should be off during meals. He further indicated it was the best time to release the seat belt because the resident could be monitored. 2. Record review revealed the annual Minimum Data Set (MDS) Assessment dated 08/12/10, revealed the facility assessed Resident #11 as requiring two (2) person assist with Activities of Daily Living (ADLs), Bed Mobility, and Transfers. Review of Resident #11's medical record revealed the facility care planned the resident as needing the assist of two (2) persons with care needs. Phone interview with Certified Nursing Assistant (CNA) #3 on 09/15/10 at 3:30 PM, revealed on 05/23/10 she provided care to assist the resident with turning and repositioning by herself. She stated the resident's fingernail had caused the skin tear secondary to the way they had crossed when she turned the resident. The CNA stated it was her fault because she did not notice Resident #11 was a two (2) person assist on the Nurse Aide Care Plan. Phone interview with Licensed Practical Nurse (LPN) #3 on 09/16/10 at 2:19 PM, revealed she had been notified by CNA #3 of Resident #11's skin tear. She further stated she assessed the resident and CNA #3 told her she was in the resident's room alone providing care. She further indicated the Nurse Aide Care Plan stated the resident was to be a two (2) person assist.	F 282	F323 **It is the policy of this facility to ensure residents receive adequate supervision and assistance to prevent accidents and injuries.** **On 7/27/10 the facility staff nurse took immediate action for Resident #13 to prevent injury by providing immediate first aid to the resident's abdomen, right arm and thigh. Resident #13 is receiving supervision with food/beverage consumption based on her assessed need. Resident #13 is receiving treatments for any impaired skin integrity.** **Beginning on 7/27/10 and continuing through 7/28/10 and ongoing, the facility Administrator/DON/Administrative Nurses and Maintenance Director have made rounds to identify potential accident hazards. On 9/17/2010 facility rounds were conducted by the Administrator, DON and Maintenance Director with no other accident hazards identified.**	

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	185197	A. BUILDING _____ B. WING _____	C 09/17/2010

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F 282	Continued From page 12 Interview with CNA #2 on 09/16/10 at 2:45 PM. who was currently caring for Resident #11, revealed her Nurse Aide Care Plan documented the resident was to have two (2) person assist with care needs.	F 282	**The MDSs of current residents and observations of current residents were completed on 7/28/10 and re-evaluation initiated on 9/17/2010 with completion on 10/7/2010 to determine assistance and assistive devices needed and utilized to prevent accidents.**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents received adequate supervision and assistance to prevent accidents and injuries for one (1) of twenty-four (24) sampled residents (Resident #13). Resident #13 spilled hot coffee on his/her abdomen which resulted in a second degree burn to the abdomen and redness to the right arm and thigh. The findings include: Review of the clinical record revealed Resident #13 was admitted on 04/23/09 with diagnoses which included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Macular Degeneration, Diabetes, Debility, Osteoarthritis, Hypertension, Anxiety and Depression.	F 323	**On 7/28/2010 current residents were assessed for needed assistance with meals. Audits were implemented to monitor point of service temperatures and provision of appropriate supervision. On 9/17/2010 current residents were re-evaluated by facility Unit Managers for assistance with meals. Auditing of point service temperatures and meal supervision was reviewed by the DON and Administrator on 9/17/2010 with no areas of concern. Ongoing, point of service temperatures will continue to assure continued compliance with review by QA Committee for need of revision to current plan** **On 7/27/10 and 10/1/2010 the House Supervisor began re-education of all staff on accident hazards and supervision to prevent accidents. This re-education**	

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F 323	Continued From page 13 Review of the 06/04/10 Minimum Data Set (MDS) Assessment revealed the facility assessed the resident to require one person to provide limited assistance with eating. Review of the 03/09/10 Resident Assessment Protocol Summary revealed the resident's vision was highly impaired related to Macular Degeneration. Review of the July 2010 Certified Nursing Assistant (CNA) Care Plan, revealed the resident required partial assistance with eating. Review of the Nurses Notes revealed on 07/27/10 the resident spilled hot coffee on his/her right arm, thigh and abdomen and sustained a 1.5 centimeter by 1.5 centimeter second degree burn to the abdomen and redness to the right arm and right thigh. The resident was in the dining room when the incident occurred. Interview on 09/14/10 at 8:00 PM with Resident #13, revealed a CNA reheated the cup of coffee, gave it to the resident, and did not provide assistance with the hot beverage. Further interview revealed the resident had poor eyesight and his/her hands were shaky. Interview on 09/16/10 at 4:30 PM with CNA #11, revealed she reheated coffee for two (2) other residents; however, the cups were switched and she inadvertently gave Resident #13 the wrong cup of coffee. Further interview revealed the resident did not receive any assistance when he/she was given the coffee. Interview on 09/17/10 at 11:55 AM with the Director of Nursing, revealed the resident's ability to self feed fluctuated; some days assistance was needed and some days it was not needed. Further interview revealed the resident did not	F 323	continued by the Administrator and SDC until all staff was re-educated. An ad hoc QA Committee Meeting was held 7/28/10 to review the results of rounds, MDS reviews, observations of residents for needed assist to prevent accidents and to evaluate the effectiveness of the action plan implemented on 7/27/10. It was deemed the facility was in compliance with regulatory requirements and facility standards for accident prevention and assessed supervision of residents. On 9/22/2010 the QA committee met to evaluate current audits and determined facility to be in compliance with determination to continue audits and interventions for ongoing monitoring. The facility Administrator/DON/Administrative Nurses and Maintenance Director will complete rounds weekly to identify and monitor for potential accident hazards. The QA Nurse will complete weekly audits to monitor for needed assistance for residents to prevent accidents. Point of service audits will continue weekly.	

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F 323	Continued From page 14 receive assistance at the time of the incident. Record review and interview with the Administrator on 09/16/10 at 9:15 AM, revealed in response to this incident the facility immediately in-serviced all staff that beverages were not to be warmed for any resident; placed all microwaves behind locked doors; and, educated licensed staff related to standards and proper food temperatures. The facility also assessed all residents to ensure the facility was providing proper assistance with meals. The facility conducted a Quality Assurance meeting on 07/28/10 to implement action plans related to the incident and informed the Medical Director of the facility's action. The facility implemented audit tools to monitor point of service temperatures, appropriate supervision during meals, and staff knowledge.	F 323	**Results of the audits and rounds will be reviewed in the monthly QA Committee meeting with revision of the plan as deemed necessary by the Committee.** **The Administrator, Maintenance Director, DON/Designee will be responsible for overall compliance.**	10/29/10
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to prepare, store, and distribute food under sanitary conditions. This was evidenced by observation of	F 371	**It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions** **On 9/14/10 the Dietary Manager immediately removed and disposed of all unlabeled and undated refrigerated food items.** **On 9/14/10 the Dietary Manager removed food items observed to be outside of required ranges, temperatures were taken on food items not previously checked and bread crumbs were removed from the bottom of the mixing bowl.**	

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F 371	Continued From page 15 food items noted to be stored in the stand alone refrigerator located on the resident trayline which were not labeled or dated; foods on the resident trayline for the evening meal of 09/14/10 were observed to be held at temperatures outside of those required for food safety; and, nine (9) of the food items for the evening meal on 09/14/10 did not have temperatures taken to ensure food safety standards were met before trayline began. In addition seven (7) trays were observed to have multiple cracks, and the standing mixer was noted to be stored covered with crumbs in the bottom of the mixing bowl. The findings include: 1. During initial tour on 09/14/10 at 9:02 AM, seven (7) individual serve bowls containing salad, six (6) individual serve bowls containing apples, sixteen (16) individual serve bowls containing peaches, and twelve (12) individual serve bowls of peaches and cottage cheese were noted to be stored in the refrigerator located on the resident trayline which were not labeled or dated. Interview with the Dietary Manager on 09/14/10 at 9:05 AM, revealed the food items were used the previous night and should have been dated before being stored in the refrigerator. 2. During initial tour on 09/14/10 at 9:15 AM, the standing mixer was noted to be stored and covered with crumbs in the mixer's bowl. Interview with the Dietary Manager on 09/14/10 at 9:15 AM, revealed she had never seen the mixer being used since she worked at the facility. However, it should be cleaned and then stored covered.	F 371	**On 9/17/10 the Dietary Manager removed all trays, plates, bowls and cups that were cracked. Sanitation rounds were completed by the Dietary Manager and company Dietician on 9/17/10 to identify sanitary condition parameters which might represent areas of concern. None were identified.** **Dietary staff were re-educated beginning 9/14/10 through 9/17/10 by the Dietary Manager regarding storage/labeling of food, removing cracked food vessels/trays from service, appropriate temperature ranges and cleaning dietary equipment/food vessels and general dietary sanitation requirements.** **Daily audits began by the Dietary Manager on 9/17/10 of food temperatures, dating/labeling food items, observing for cracked food vessels/trays, cleanliness of dietary equipment/food vessels and general dietary sanitation for one week.**	

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	185197	A. BUILDING _____ B. WING _____	C 09/17/2010

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F 371	Continued From page 16 3. During the evening meal observation on 09/14/10 at 5:00 PM, the Certified Cook #1 took the temperatures of food for the resident trayline. The pureed potato salad was one-hundred six (106) degrees Farenheit, the pureed tuna was seventy-nine (79) degrees Farenheit and the pureed vegetable salad was sixty-nine (69) degrees Farenheit. Trayline was noted to begin and residents were served these food items whose temperatures were not held at the correct temperature ranges for food safety. Interview with the Dietary Manager on 09/16/10 at 9:15 AM, revealed the pureed potato salad, pureed tuna salad, and pureed vegetable salad were to have been served as cold food items. She further indicated cold foods should not be held at a temperature higher than forty-five (45) degrees Farenheit. 4. During the evening meal observation on 09/14/10 at 5:00 PM, it was noted while the Certified Cook #1 checked the temperatures he did not check the temperatures of all the food being held on resident trayline. Nine (9) food items did not have temperatures taken before the trayline was started. The food items which did not have temperatures taken included the chicken noodle soup, chicken strips, pureed chicken strips, ground chicken, green bean puree, mashed potatoes, gravy, corn, and corn dogs. Interview with the Certified Cook #1 on 09/14/10 at 6:35 PM, revealed he was trying not to use the food items which were alternates; however, he kept receiving tray cards which labeled dislikes of fish. He also indicated that his temperature log did not have any extra space to document the	F 371	**Ongoing monitoring will continue 5 times per week by the Dietary Manager/Designee per daily quick rounds. The Administrator will complete weekly quick rounds. The facility Dietician will complete monthly sanitation rounds.** **Results of the audits will be reviewed in the monthly QA Committee meeting with revision of the plan per QA Committee recommendations.** **The Administrator and Dietary Manager will be responsible for overall compliance.**	10/29/10

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F 371	Continued From page 17 food items. Interview with the Dietary Manager on 09/14/10 at 9:15 AM, revealed every food item on the trayline should have had a temperature taken just to be on the safe side. She further indicated she had always assumed the Dietary staff did take and document the temperatures. 5. During evening meal observation on 09/14/10 at 4:55 PM through 6:35 PM, seven (7) resident trays were noted to be cracked and in poor repair. Interview with the Dietary Manager on 09/14/10 at 4:55 PM, revealed the trays were replaced approximately once per month, and the old trays should be disposed when discovered to be in poor repair.	F 371		
F 441 S8=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	**It is the practice of this facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** **On 9/17/10 the DON replaced the oxygen tubing for residents #3 and #13.** **The oxygen tubing for residents #3 and 13 along with other residents receiving oxygen were secured with a clip which attached to his/her chair or clothing to prevent the tubing from touching on the floor.**	

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F 441	Continued From page 18 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to utilize appropriate measures to prevent the development and transmission of infection within the facility by failing to ensure oxygen tubing remained off of the floor for two (2) of twenty-four (24) sampled residents (Resident #13 and #3). The findings include: 1. Review of the clinical record revealed Resident #13 was admitted to the facility on 04/23/09 with diagnoses which included Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. Observation during the initial tour on 09/14/10 at 9:45 AM, revealed Resident #13 was sitting in a	F 441	**On 9/17/2010 facility residents were observed by the Infection Control Nurse for symptoms of infectious processes related to infection control practices and none were identified. A review on 9/17/2010 by the Director of Nursing and Infection Control Nurse of the tracking and trending of infections in the facility revealed no pattern related to inappropriate infection control techniques.** **All residents with oxygen tubing received a clip to attach the tubing to the resident's chair or person to avoid tubing touching the floor.** **In conjunction with this action education was completed with all nursing and activity staff to ensure extra tubing is placed in a bag attached to the concentrator with the drawstring pulled tightly for proper placement.** **On October 28, 2010 the SDC completed education with nursing staff regarding infection control techniques to prevent infection to residents.**	

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F 441	Continued From page 19 wheelchair in his/her room, oxygen was in use, and the oxygen tubing was observed on the floor. Further observation on 09/16/10 at 11:40 AM revealed resident was sitting in the Dining Room and the oxygen tubing again was observed on the floor. 2. Review of the clinical record revealed Resident #3 was admitted to the facility on 03/08/10 with diagnoses which included Lung Disease and Congestive Heart Failure. Observation on 09/16/10 at 11:40 AM, revealed the resident was sitting in the Dining Room and the oxygen tubing was observed on the floor. Interview on 09/17/10 at 11:55 AM with the Director of Nursing, revealed she was unaware the oxygen tubing should not touch the floor, she was only aware that the nasal cannula should not touch the floor.	F 441	**The facility CQI team will daily audit residents with active infections for breaches in infection control techniques. QA Nurse and Infection Control Nurse will randomly audit and observe infection control techniques with return demonstration by staff to assure ongoing compliance.** **The QA Nurse and House Supervisor will conduct a weekly audit to monitor dating, labeling and appropriate placement of oxygen tubing.** **Results of the audits will be reviewed by the QA Committee monthly with revisions to the plan as deemed by the Committee.** **The Administrator, DON, Infection Control Nurse and QA Nurse will be responsible for overall compliance.**	10/29/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/16/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 09/16/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".	K 000	**Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest again the facility, the Administrator, employees, agents or other individuals who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs.**	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the fire extinguisher used in the Kitchen area was maintained according to NFPA standards. The findings include: Observation on 09/16/10 at 10:31 AM, revealed the "K" type fire extinguisher located in the Kitchen area did not have the required sign. The observation was confirmed with the Maintenance Director. Interview on 09/16/10 at 10:31 AM, with the Maintenance Director, revealed he was unaware of the missing sign for the "K" type fire extinguisher. Reference: NFPA 96 (1999 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.	K 069		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Thornton — TITLE: Administrator — (X6) DATE: 10/31/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	185197	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHPOINT/LEXINGTON HEALTHCARE CENTER	1600 TRENT BOULEVARD LEXINGTON, KY 40515

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K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure oxygen supply areas where maintained according to NFPA standards. Also, electrical switches and/or the electrical outlets locations did not meet the requirements for the Life Safety Code. The findings include: Observation on 09/16/10 at 9:30 AM, revealed the oxygen supply room on the Amelia Hall contained combustible (paper and plastic) materials located within two (2) feet of the oxygen cylinders. The observation was confirmed with the Maintenance Director. Interview on 09/16/10 at 9:30 AM with the Maintenance Director, revealed he was unaware of the combustible materials being located so close to the oxygen cylinders.	K 076	**The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility. This plan of correction is submitted as facility's credible allegation of compliance** **Corrective action completed by October 28,2010** K069 It is the practice of this facility to ensure all fire extinguishers are maintained according to NFPA standards. The facility immediately posted appropriate signage for the "K" type fire extinguisher. Temporary signage was placed on September 16, 2010 with permanent signage ordered, received and placed on September 28, 2010. The facility maintenance director evaluated all fire extinguishers present in the facility to ensure appropriate placement and signage	10/28/10

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K 076	Continued From page 2 Observation on 09/16/10 at 10:08 AM, of the oxygen supply room at Combs Nurses Station revealed there were two (2) light switches located three (3) feet from the floor level, and one (1) electrical outlet located one (1) foot from the floor level. Further observation revealed the oxygen supply room on the Breckenridge Hall, had one (1) light switch located three (3) feet from the floor. The observation was confirmed with the Maintenance Director. Interview on 09/16/10 at 10:08 AM, revealed he was not aware the electrical switches and/or the electrical outlets locations did not meet the requirements for the Life Safety Code. Reference: NFPA 99 (1999 Edition). 4-3.1.1.2 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas,	K 076	The maintenance director inserviced all maintenance staff and the safety committee on required placement and appropriate signage of fire extinguishers. An audit will be conducted on a monthly basis to assure appropriate signage of all fire extinguishers. The facility Preventative Maintenance program will monthly check appropriate signage of fire extinguishers with any concerns to be audited and followed through facility QA committee Findings will be reviewed by the facility QA committee to monitor ongoing compliance. Administrator and Maintenance Director will be responsible for overall compliance. K076 It is the practice of this facility to ensure all medical gas storage and administration areas are protected in accordance with NFPA 99 Standards for Health Care Facilities.	10/28/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 3 liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076	Oxygen supply rooms were immediately corrected with storage of all combustible materials within proper parameters of 5 ft from oxygen cylinders. On September 20, 2010 all affected light switches were moved to the required heights of 5 ft. On September 20, 2010 electrical outlet were disabled, removed and covered and are non functional. All staff were inserviced by the maintenance director on standards for oxygen storage on September 20, 2010. All oxygen storage rooms will be audited weekly as a part of the facility preventative maintenance program. Results of these audits will be monitored monthly through the facility Quality Assurance Program Results of these audits will be reviewed by the facility QA committee for evaluation and need of revision	10/28/10